

**BENEFIT SUMMARY**  
**THE BOEING COMPANY**  
**TRADITIONAL MEDICAL PLAN (TMP)**



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

SPEEA WTPU  
 Early Retiree (retire date of June 30, 2007 or before)  
 Effective July 1, 2009 – December 31, 2009

For medically necessary services rendered by a Network or Non-Network provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the copay, deductible, or a combination of the two has been met.

**This is a brief summary of benefits, it is not a certificate of coverage. For full coverage provisions, including limitations and exclusions, refer to the Summary Plan Description and the contract on file with your group or:**

Call Boeing Customer Service at **1-800-422-7713** or visit our Web site at [www.regence.com/boeing](http://www.regence.com/boeing)  
 Use [myRegence.com](http://myRegence.com) for 24-hour access to your health information regarding claims and benefits

Benefits	Network	Non-Network
<b>Annual Deductible*</b> Copays do not count toward the deductible.	\$100 per individual; \$300 per family of 3 or more.***	
<b>Annual Out-of-Pocket Maximum</b>	\$1,000 per individual; network/non-network combined.*** \$2,000 per family, but not more than \$1,000 for any person; network/non-network combined.***	
<b>Alternative Care</b>		
Inpatient	95%	60%
Outpatient	100%; \$15 copay*	60%
Includes services received by an acupuncturist only. Naturopaths, naturopathic services and massage therapists are not covered. Refer to Summary Plan Description for details.		
<b>Ambulance Services</b>	95%	See network provisions
<b>Hearing Aids</b> \$600 maximum limited to one aid per ear every 3 consecutive benefit years; network/non-network combined.	95%	60%
<b>Home Health</b>	100%	100%
<b>Durable Medical Equipment, Prostheses and Orthotics</b>	95%	60%
<b>Hospital Facility</b> Hospital Safety Incentive applies**		
Inpatient/Outpatient	95% or 100%**	60%
Emergency Room (for true medical emergencies) **For Hospital Safety Incentive facilities: Visit <a href="http://www.regence.com/boeing">www.regence.com/boeing</a> or call 1-800-422-7713.	95% or 100%**; \$50 copay* (waived if admitted)	See network provisions
<b>Mental Health*</b> (ValueOptions Network)		
Inpatient	95%	50%;20 days per benefit year
Outpatient	80%	50%;20 visits per benefit year
Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.		
<b>Physical, Occupational and Speech Therapy</b> Refer to Summary Plan Description for details.	95%	60%
<b>Prescription Drugs (Medco)*</b> Please refer to Medco at 1-800 841-2797 or visit Medco Web site at <a href="http://www.medcohealth.com">www.medcohealth.com</a> .		
<b>Physician Services</b>		
Inpatient	95%	60%
Outpatient	100%; \$15 copay*	60%

Benefits	Network	Non-Network
<b>Preventive Care</b> Refer to Summary Plan Description for details. Routine exams (1 exam every 3 calendar years for employee/spouse under age 35; 1 exam every calendar year for employee/spouse age 35 and older) Well child exams (ages birth through age 5 only), childhood immunizations (not subject to preventive dollar maximum)	100% \$200 maximum per individual per benefit year. (deductible does not apply)	Not covered
Screening Exams: Includes Mammograms, Pap tests, Prostate cancer screening and related office visits.	100% Not subject to preventive care maximum (deductible does not apply)	Not covered
<b>Skilled Nursing Facility and Hospice</b>	100%	100%
<b>Spinal Manipulations</b> Limited to a combined 26 spinal and extremity manipulation visits per benefit year; network/non-network combined.	100%; \$15 copay*	60%
<b>Substance Abuse</b> (ValueOptions Network) Inpatient Outpatient 2 courses of treatment lifetime maximum; inpatient/outpatient and network/non-network combined.  Care must be coordinated through the Boeing Helpline (ValueOptions) at 1 (800) 892-1411.	95% 95%	50% 50%  Inpatient/outpatient limited to \$5,000 per course of treatment network-non-network combined.
<b>Transplants</b> Refer to Summary Plan Description for details.	See professional and hospital facility benefits	60%
<b>Vision Care*</b> Routine vision care services are covered through Vision Service Plan (VSP). Contact VSP at 1(800) 877-7195 for details.		

\*Employee costs do not apply to the annual out-of-pocket maximum.

\*\*\*The dollar amounts reflected are half the normal deductible and OOP amounts due to the six-month benefit period. Effective January 1, 2010, these amounts will reset in full.

#### Lifetime Maximum:

\$1,500,000 per individual.

#### Out-of-Pocket (OOP) Maximum:

The benefits of this plan will be provided until the OOP maximum is reached. Thereafter, this plan will provide benefits at 100% of the allowed amount for the remainder of the benefit year. Any balances of charges not covered by this plan will be your responsibility to pay and do not apply to the OOP maximum. The annual deductible, all copays (including mail order prescription and emergency room copays), substance abuse care, mental health care, temporomandibular joint disorder and tobacco cessation do not apply to your OOP maximum.

#### Emergency Room:

Emergency room treatment at either a network or non-network facility is paid at the network level if it is a true medical emergency. Care at a non-network facility when the condition is not a true medical emergency, will be paid at the non-network level.

Benefit Summary

#### Network Versus Non-Network Providers:

To receive the highest benefit level, you must receive services from a Blue Cross Blue Shield Plan Preferred Provider Organization (PPO) provider. Networks are available in nearly all Boeing locations in the U.S. To find a network provider, call **1-800-810-BLUE (2583)**. If you receive care where no network is available, benefits will be paid at the network level. You may also visit the Boeing Health and Welfare Plans Web site at:

<http://www.boeing.com/express>

or call **1-866-473-2016**

for names of PPO providers with the local Blue Cross and/or Blue Shield plan.

#### Hospital Preadmission Approval:

All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is the responsibility of the member and must be obtained to ensure that full plan benefits will be provided.

#### Exclusions and Limitations to Coverage:

The non-covered services and supplies include, but are not limited to: acupuncture, except as specified; benefits covered by Medicare, auto insurance or government programs; substance abuse, except as specified; conditions related to military service or war; cosmetic surgery, except as specified; dentistry, dental x-rays or hospitalization for dentistry; intentionally self-inflicted injuries; investigational services or supplies; mental disorders, except as specified; obesity, unless approved in advance by the service representative according to written guidelines; occupational injury or disease; orthoptics, visual analysis, therapy or training, except as specified; prescription drugs, except as specified; private duty nursing or hourly nursing charges; services or supplies not medically necessary for illness or injury, except as specified; surgery or treatment for transsexualism or certain treatments for infertility; treatment of dyslexia, except as specified.

July 2009